marriage and family counseling, psychosocial rehabilitation, or a closely related field; (7-1-94)T

g. An occupational therapist shall be licensed in accordance with Chapter 54, Idaho Code. (7-1-94)T

h. A CSP mental health services technician shall hold certification from the Division of Family and Community Services, according to standards developed by that Division, and work under the direct supervision of professional staff listed in 112.04.a through g. (7-1-94)T

05. Record Requirements. In addition to the development and maintenance of the treatment plan, the following documentation must be maintained by the provider: (7-1-94)T

a. Name of recipient; and (7-1-94)T

b. Name of the provider agency and person providing the service; and (7-1-94)T

c. Date, time, and duration of service; and (7-1-94)T

d. Activity record describing the recipient and the service provided. (7-1-94)T

06. Payment for Services. Payment for CSP services must be in accordance with rates established by the Department. (7-1-94)T

a. Payment for services shall not duplicate payment made to public or private entities under other program authorities for the same purpose. (7-1-94)T

b. Only one staff member may bill for an assessment, treatment plan, or case review when multiple CSP staff are present. (7-1-94)T

c. Group therapy service must be specified in the recipient's treatment plan. (7-1-94)T

d. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Idaho Code. CSP staff shall not be paid for other medical procedures. For example, changing dressings on a wound. (7-1-94)T

e. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules shall be cause for recoupment of payments for services, sanctions, or both. (7-1-94)T

f. The provider shall provide the Department with access to all information required to review compliance with these rules. (7-1-94)T

g. Psychiatric or psychological evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (7-1-94)T

h. Psychological evaluations are reimbursable if provided by a qualified clinician, in accordance with 112.04.d, under the direction of a psychologist, Ph.D. (7-1-94)T

i. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with development of a service plan are reimbursable. (7-1-94)T

07. Service Limitations. The following service limitations shall apply to CSP services, unless otherwise authorized by the Division of Family and Community Services. (7-1-94)T

a. A combination of any evaluation or diagnostic services are limited to a maximum of six (6) hours in a calendar year. (7-1-94)T

b. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year. (7-1-94)T

c. Community crisis support services are limited to a maximum of five (5) consecutive days and must receive prior authorization from the Division of Family and Community Services. (7-1-94)T

d. Individual and group psychosocial rehabilitation services are limited to twenty hours (20) per week and must receive prior authorization from the Division of Family and Community Services. Services in excess of twenty (20) hours require additional review and prior authorization by the Division. (7-1-94)T

114. CLINIC SERVICES - DIAGNOSTIC SCREENING CLINICS. The Department will reimburse medical social service visits to clinics which coordinate the treatment between physicians and other medical professionals for recipients which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (4-1-91)

01. Multidisciplinary Assessments and Consultations. The clinic must perform onsite multidisciplinary assessments and consulations with each recipient and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the recipient will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. (4-1-91)

02. Billings. No more than five (5) hours of medical social services per recipient may be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges recipient treatments and provides medical information to providers which have agreed to coordinate the care of their patient. (4-1-91)

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. (12-31-91)

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. (4-1-91)

05. Services Reimbursed. Services performed by a diagnostic and screening clinic will be reimbursed under a fee for service basis as established by Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, Section 406., "Rules Governing Medicaid Provider Reimbursement in Idaho." (12-31-91)

115. CLINIC SERVICES -- MENTAL HEALTH CLINICS. Pursuant to 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a recipient who is not an inpatient in a hospital or nursing home except as specified under Subsection 115.05.d. The mental health clinic must be approved by the Department and be under the direction of a licensed physician. (12-31-91)

01. Care and Services Provided. (12-31-91)

a. Services must be provided specifically in conjunction with a medically ordered plan of care when delivered by licensed, qualified professionals employed full or part-time within a clinic. (11-10-81)

b. All treatment must be based on an individualized assessment of the patient's needs, and provided under the direct supervision of a licensed physician. (11-10-81)

c. All medical care plans must: (11-10-81)

i. Be dated and fully signed with title identification by both the prime therapist(s) and licensed physician; and (11-10-81)

ii. Contain the diagnosis, problem list, type, frequency, and duration of treatment; and (11-10-81)

iii. Be reviewed and authorized and signed within thirty (30) days of implementation; and (11-10-81)

iv. Be reviewed within one hundred twenty (120) days and every one hundred twenty (120) days thereafter; and (11-10-81)

v. Be completely rewritten and authorized annually. (11-10-81)

d. Licensed, qualified professionals providing clinic services to eligible MA recipients must have, at a minimum, one (1) or more of the following degrees: (11-10-81)

i. Psychiatrist, M.D.; or (11-10-81)

ii. Physician, M.D.; or (11-10-81)

iii. Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)

iv. Licensed Certified Social Workers, Licensed Social Workers; or (11-10-81)

v. Psychiatric Nurse, R.N.; or (11-10-81)

vi. Mental Health Rehabilitation Specialist, Registered Occupational Therapist, O.T.R. (11-10-81)

02. Care and Services not Covered. (11-10-81)

a. The MA Program will not pay for clinic services rendered to MA recipients residing in in-patient medical facilities including, but not limited to, nursing homes or hospitals; or (11-10-81)

b. Any service or supplies not included as part of the allowable scope of the MA Program; or (11-10-81)

c. Services provided within the clinic framework by persons other than those qualified to render services as specified in Section 115. (12-31-91)

03. Evaluation and Diagnostic Services.

a. Medical psychosocial intake histories must be contained in all case files. (11-10-81)

b. Information gathered will be used for establishing a recipient data base used in part to formulate the diagnosis and treatment plan. (11-10-81)

c. The medical psychosocial intake is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following degrees: (11-10-81)

i. Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)

ii. Licensed Certified Social Worker or Licensed Social Worker; or (11-10-81)

iii. Psychiatric Nurse, R.N.; or (11-10-81)

iv. Licensed Physician, M.D. (11-10-81)

d. If an individual who is not eligible for MA receives intake services from any staff not having the required degree(s) as provided in Subsection 115.03.c., and later becomes eligible for MA, a new intake assessment and treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. (12-31-91)

e. Any provider of evaluation, diagnostic service, or treatment designed by any person other than a person designated as qualified by these rules, is not eligible for reimbursement under the MA Program. (11-10-81)

f. Psychiatric or psychological testing may be provided in conjunction with the medical psychosocial intake history as a reimbursable service. (11-10-81)

g. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of a medical care treatment plan are reimbursable. (11-10-81)

h. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the recipient's file for documentation purposes. (11-10-81)

i. All data gathered must be directed towards formulation of a written diagnosis, problem list, and treatment plan which specifies the type, frequency, and anticipated duration of treatment. (11-10-81)

j. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services provided to an eligible recipient in a calendar year. A calendar year begins on the first date of service provided to an eligible recipient. (11-10-81)

04. Treatment Services.

a. Individual and group psychotherapy must be provided in accordance with the goals specified in the written medical treatment plan. (11-10-81)

b. Family-centered psychosocial services must include at least two (2) family members and must be delivered in accordance with the goals of treatment as specified in the medical treatment plan. (11-10-81)

c. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (11-10-81)

i. Emergency services provided to an eligible recipient prior to intake and evaluation is a reimbursable service but must be fully documented in the recipient's record; and (11-10-81)

ii. Each emergency service will be counted as a unit of service and part of the allowable limit per recipient unless the contact results in hospitalization; and (11-10-81)

d. Psychotherapy services may be provided to recipients residing in a nursing facility if the following criteria are met: (11-29-91)

i. The recipient has been identified through the PASARR level II screening process as requiring psychotherapy as a specialized service; and (11-29-91)

ii. The service is provided outside the nursing facility at a clinic location or other location where clinic staff is available; and (11-29-91)

iii. Services provided are: (11-29-91)

(a) Supported by the independent evaluations completed and approved by the Mental Health Authority; and (11-29-91)

(b) Incorporated into the recipient's medical care plan; and (11-29-91)

(c) Directed toward the achievement of specific measurable objectives which include target dates for completion. (11-29-91)

e. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 115.04.a. through 115.04.d. must have, at a minimum, one (1) or more of the following degrees: (12-31-91)

i. Psychiatrist, M.D.; or (11-29-91)

ii. Physician, M.D.; or (11-10-81)

iii. Psychologist, Ph.D., Ed.D., M.A./M.S; or (11-10-81)

iv. Licensed Certified Social Workers, Licensed Social Workers; or (11-10-81)

v. Psychiatric Nurse, R.N. (11-10-81)

f. Psychotherapy services as set forth in Subsections 115.04.a. through 115.04.c. are limited to forty-five (45) hours per calendar year. (12-31-91)

g. Chemotherapy consultations must be provided by a physician or licensed nurse practitioner in direct contact with the recipient. (11-10-81)

i. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the treatment plan; and (11-10-81)

ii. Chemotherapy treatment can be part of the medical care plan and frequency and duration of the treatment must be specified. (11-10-81)

h. Nursing services, when physician ordered and supervised, can be part of the recipient's medical care plan. (11-10-81)

i. Licensed and qualified nursing personnel can supervise, monitor, and/or administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (11-10-81)

ii. Such treatment can be part of the recipient's medical care plan and frequency and duration of the treatment must be specified. (11-10-81)

i. Partial care services will be directed toward the maintenance of socio-emotional levels, reduction of psychosocial dysfunctioning, and the promotion of psychosocial levels of functioning. (11-10-81)

i. To qualify as a partial care service, the service must be offered a minimum of three (3) continuous hours daily, four (4) days per week; and (11-10-81)

ii. Treatment will be limited to fifty-six (56) hours per week per eligible recipient; and (7-8-90)

iii. Partial care services offered on an extension basis less than this standard are allowable when such services are directly affiliated with a partial care service that meets this standard; and (11-10-81)

iv. Partial care services will be part of the recipient's medical care plan which must specify the amount, frequency, and expected duration of treatment; and (11-10-81)

v. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the following degrees: (11-10-81)

(a) Psychiatrist, M.D.; or (11-10-81)

(b) Physician, M.D.; or (11-10-81)

(c) Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)

(d) Licensed Certified Social Worker, Licensed Social Worker; or (11-10-81)

(e) Registered Nurse, R.N.; or (11-10-81)

(f) Registered Occupational Therapist. (11-10-81)

05. Record Keeping Requirements.

a. Each clinic will be required to maintain records on all services provided to MA recipients. (11-10-81)

b. The records must contain a current treatment plan ordered by a physician and must meet the requirements as set forth in Subsection 115.01.c. (12-31-91)

c. The records must: (11-10-81)

i. Specify the exact type of treatment provided; and (11-10-81)

ii. Who the treatment was provided by; and (11-10-81)

iii. Specify the duration of the treatment; and (11-10-81)

iv. Contain detailed records which outline exactly what occurred during the therapy session or recipient contact; and (11-10-81)

v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (11-10-81)

d. Any service not adequately documented in the recipient's record by the signature of the therapist providing the therapy or recipient contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (11-10-81)

e. Any treatment or contact provided as a result of a treatment plan performed by any staff other than as set forth herein will not be eligible for reimbursement by the Department. (11-10-81)

f. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the recipient are subject to recoupment. (11-10-81)

06. Payment Procedures.

a. Payment for clinic services will be made directly to the clinic and will be in accordance with rates established by the Department for the specific services. (11-10-81)

b. Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the MA recipient for any portion of any charges incurred for the cost of his care. (11-10-81)

c. All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payors will be required by the Department. (11-10-81)

d. Payment for the administration of injections must be in accordance with rates established by the Department. (11-10-81)

116. TARGETED CASE MANAGEMENT FOR THE MENTALLY ILL. The Department will purchase case management (CM) services for adult Medicaid recipients with severe disabling mental illness. Services will be provided by an organized provider agency which has entered into a provider agreement with the Department. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services. (8-1-92)

01. Eligible Target Group. Only those individuals who are mentally ill and eighteen (18) years of age or older who are at risk of using high cost medical services associated with frequent exacerbations of mental illness are eligible for CM services. (8-1-92)

a. The following diagnostic and functional criteria will be applied to determine membership in this target population: (8-1-92)

i. Diagnosis: A condition of severe and persistent mental illness and a diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) within one of the following classification codes for: (8-1-92)

(a) Schizophrenia - 295.1,.2,.3,.6 and .9; (8-1-92)

(b) Organic mental disorders associated with Axis III physical disorders or conditions, or whose etiology is unknown - 293.00, 293.81, 293.82, 293.83, 294.00, 294.10, 294.80, 310.10; (8-1-92)

(c) Affective disorders - 296.2, 296.3, 296.4, 296.5, 296.6, 296.7, 300.4, 301.13, 311.0; (8-1-92)

(d) Delusional disorder - 297.1; (8-1-92)

(e) Other psychotic disorders - 295.4, 295.7, 297.3, 298.8 and 298.9; (8-1-92)

(f) Personality disorders - 301.00, 301.22, 301.83. (8-1-92)

(g) If the only diagnosis is one or more of the following, the person is not included in the target population for CM services: (8-1-92)

(i) Mental retardation; or (8-1-92)

(ii) Alcoholism; or (8-1-92)

(iii) Drug abuse. (8-1-92)

ii. Functional limitations: The psychiatric disorder must be of sufficient severity to cause a disturbance in the role performance or coping

skills in at least two (2) of the following areas, on either a continuous (more than once per year) or an intermittent (at least once per year) basis: (8-1-92)

(a) Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history. (8-1-92)

(b) Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support him or manage his finances without assistance. (8-1-92)

(c) Social/interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (8-1-92)

(d) Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family. (8-1-92)

(e) Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (8-1-92)

(f) Housing: Has lost or is at risk of losing his current residence. (8-1-92)

(g) Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior which results in intervention by law enforcement and/or the judicial system. (8-1-92)

(h) Health: Requires assistance in maintaining physical health or in adhering to medically prescribed treatment regimens. (8-1-92)

b. Recipients may reside in adult foster care, residential care, semi-independent living, room and board or their own homes. (8-1-92)

c. Recipients may be receiving homemaker, personal care, home health, respite or other services. (8-1-92)

d. Recipients who elect hospice services as found in Section 104., or are receiving case management services through another program are excluded from CM services. (8-1-92)

02. Services Descriptions. CM services shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational and social services in the least restrictive, most appropriate and most cost-effective setting. CM services shall consist of the following core functions: (8-1-92)

a. Assessment: A CM provider must have the capacity to perform written comprehensive assessments of a person's assets, deficits and needs. Assessment is an interactive process with the maximum feasible involvement of the recipient. Should the assessments reveal that the person does not need CM services, appropriate referrals will be made to meet other needs of the participant. All the following areas must be evaluated and addressed: (8-1-92)

i. Psychiatric history and current mental status: Includes but is not limited to age of onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the client manifests, is the client able to identify his symptoms, medication history; substance abuse history, history of mental ill-

v. Reference to any formal services arranged, including specific providers where applicable; and (8-1-92)

vi. Planned frequency of services initiated. (8-1-92)

c. Crisis Assistance. Crisis assistance services are those case management activities that are needed in addition to the assessment and ongoing case management hours in emergency situations. These are necessary activities to obtain services needed to ensure the health and/or safety or to prevent hospitalization or incarceration of a recipient. Crisis assistance may be provided prior to or after the completion of the assessments and individual service plan. (8-1-92)

d. Linking/Coordination of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as: assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face-to-face contact with the recipient at least every thirty (30) days. (10-22-93)

e. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation and Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system. (10-22-93)

03. CM Provider Agency Qualifications. Case management provider agencies must meet the following criteria: (8-1-92)

a. Utilization of a standardized intake and prescreening process for determining whether or not Medicaid eligible individuals are included in the target group for case management services. Prescreening must be effective in sorting out who does and who does not need a full assessment of needs for CM. (8-1-92)

b. Demonstrated capacity in providing all core elements of case management services to the target population including: (8-1-92)

i. Comprehensive assessment; and (8-1-92)

ii. Comprehensive service plan development and implementation; and (8-1-92)

iii. Crisis assistance; and (8-1-92)

iv. Linking/coordination of services; and (8-1-92)

v. Encouragement of Independence. (10-22-93)

c. Provides clients of the agency, the availability of a case manager on a twenty-four (24) hour basis to assist them in obtaining needed services. (8-1-92)

04. CM Provider Staff Qualifications. All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual

CM providers and assure that the following qualifications are met for each individual CM provider: (8-1-92)

a. Must be a psychiatrist, M.D., D.O.; or physician, M.D., D.O.; or psychologist, Ph.D., Ed.D., M.A./M.S.; or social worker with a valid Idaho social work license issued by the Board of Social Work Examiners; or nurse, R.N.; or have a B.A./B.S. in a human services field and at least one year experience in the psychiatric or mental health field. (8-1-92)

b. A total caseload per case manager of no more than twenty (20) individuals. The Bureau may grant a waiver of the caseload limit when requested by the agency. The following criteria must be met to justify a waiver: (8-1-92)

i. The availability of case management providers is not sufficient to meet the needs of the service area. (8-1-92)

ii. The recipient that has chosen the particular agency or individual case manager that has reached their limit, has just cause to need that particular agency or manager over other available agencies/managers. (8-1-92)

iii. The request for waiver must include: (8-1-92)

(a) The time period for which the waiver is requested; (8-1-92)

(b) The alternative caseload limit requested; (8-1-92)

(c) Assurances that the granting of the waiver would not diminish the effectiveness of the CM agency, violate the purposes of the program, or adversely affect the recipients' health and welfare. (8-1-92)

iv. The Bureau may impose any conditions on the granting of the waiver which it deems necessary. (8-1-92)

v. The Bureau may limit the duration of a waiver. (8-1-92)

05. Recipient's Choice. The eligible recipient will be allowed to choose whether or not he desires to receive CM services. All recipients who choose to receive CM services will have free choice of CM providers as well as the providers of medical and other services under the Medicaid program. (8-1-92)

06. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (Subsection 116.02.) provided to members of the eligible target group by qualified staff. (8-1-92)

a. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (8-1-92)

b. Payment will not be made for CM services provided to individuals who are inpatients in nursing homes or hospitals. (8-1-92)

c. Reimbursement for the initial evaluation and individual service plan development shall be paid based on an hourly rate, not to exceed eight (8) hours. The rate will be established by the Bureau. (8-1-92)

d. Reimbursement for on-going case management services shall be made on an hourly rate for service delivered. The rate will be established by the Bureau. (8-1-92)

e. Medicaid reimbursement shall be provided only for the following case management services: (8-1-92)